LETTERS TO THE EDITOR

Syphilis and HIV infection

In 1990, of 29 patients presenting with syphilis, to the General Dermatological Department in Barcelona, 10 were also seropositive for HIV. Eight patients were men. Seven were black West African immigrants, and the remainder were white local residents. The main risk factor for HIV infection among the white patients was the use of parenteral heroin, whereas among the African patients it was sexual intercourse with local prostitutes. Early syphilis (primary or secondary stages) was present in four patients; the other six had latent or late syphilis. Follow up studies in two patients disclosed abnormalities, three patients had no clinical signs and the CSF examination was normal, and the other five were lost. One patient suffered from right hemiparesis and irritability. Physical examination revealed brown macular lesions in the palms and soles, but no fever or meningeal symptoms. CT disclosed small temporal infarcts in the left hemisphere. This patient had received 7·2 megaunits of benzathine-penicillin 18 months previously as a treatment for a secondary syphilis. The RPR titres, which had been negative after therapy, reached a value of 1/64, and the titre of TPHA was 1/80. CSF examination disclosed high protein levels, mononuclear pleocytosis, decreased glucose levels and positive VDRL. The patient was then treated with intravenous crystalline penicillin G, 4 megaunits every 4 h for 14 days. After this time the neurological symptoms had disappeared and the routine CSF examination was normal. The VDRL was negative 40 days later. The other patient had no clinical signs of neurological disease, but increased protein levels, increased mononuclear cells and decreased glucose levels in the CSF, together with an increased titre of RPR (1/64) and TPHA (1/2560) in the serum. The patient had been treated with 2·4 megaunits of benzathine-penicillin six months before in the course of primary syphilis. At that time he had been discovered to be seropositive for HIV. These observations further emphasise the high incidence of syphilis and concomitant HIV infection, as well as the failure of recommended doses of penicillin in the treatment of syphilis in patients additionally infected with HIV.[1–3] It is suggested, therefore, that higher and prolonged doses of penicillin should be considered in the treatment of these patients.

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Rising incidence of genital herpes in an STD clinic in North India

In the light of the changing epidemiology of sexually transmitted diseases, we would like to share our experience, especially about genital herpes in the STD clinic situated in an urban town in India (population 600 000). While the bacterial STDs (syphilis, gonorrhoea, chancroid) continue to be a major public health problem in this region, genital herpes is now rapidly emerging as another. The recognition, in recent years, that genital ulcer disease especially genital herpes, may be a marker of underlying HIV infection[1] adds significance to this disease. In addition, unlike the bacterial STDs, this disease is difficult to treat and control. In the pre AIDS era in India, before 1986, an average of 15·5 cases/year were seen in our clinic. Subsequently, from 1986–90, an average of 34 cases/year were seen. We found that whereas in 1977, only 12 new cases of genital herpes were recorded in our clinic, this had risen to 44 new patients in 1990. These figures, though small, reflect almost a four fold rise in genital herpes in 13 years.

Similar trends have been reported from Western countries. In the UK, 7547 cases were seen in 1976 in STD clinics, which increased to 17 966 cases in 1987.[2]

The Center for Disease Control has estimated that on an average there are between 200 000 and 500 000 new cases of herpes each year in the USA. The same is true of the trend in South East Asia.[3] In our

population in spite of the rather small and heterogenous material examined we find that the trends are parallel to those seen elsewhere indicating the global nature of the current herpes pandemic. The fact that most other STDs especially the bacterial ones are treated at the primary level by virtue of the large number of currently available antibiotics, all easily available over the counter, herpes is likely to remain a major public health problem. Geographic and socioeconomic influences as stated by Guinan *et al*[4] do not seem to play such a role in our population. Asymptomatic infection plays a major role in maintaining viral circulation in society, while the sexual activity, age at first intercourse and type of contraceptives used may influence the risk of acquisition. These factors have to be borne in mind when developing an effective control programme. At present there is no such programme on a national scale for herpes but judging from the trends projected, it may very soon become a necessity.

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Screening for *Chlamydia trachomatis* in a Turkish population

In the last few years *Chlamydia trachomatis* has been recognised as one of the most important sexually transmitted pathogens. Genital infections due to this organism present a major world-wide public health problem.

We evaluated 93 out of 100 endocervical specimens obtained from nonpregnant women in their first visit to the gynaecology out-patient clinic in the Ege University Hospital, irrespective of their reason for attendance. The patient group consisted of both symptomatic and asymptomatic patients. The patients were grouped according to their ages, subjective symptoms and cervical lesions. Specimens were tested by a commercially available direct immunofluorescence test kit (Chlamyset, Orion Diagnostica, Finland). Specimens were considered positive if ten or more fluorescing elementary bodies were seen. The overall positivity rate was 34·4% (32/93). The results are shown in the table.

Table The rates of genital chlamydial infection in different patient groups

Groups	Number of patients	DFA positive	
		Number	%
Age (years)			
< 30	34	9	26·5
30–40	48	19	39·6
> 40	11	4	36·4
Symptoms and signs			
Group I*	37	12	32·4
Group II†	45	17	37·8
Group III‡	11	3	27·3
Total	93	32	34·4

*Patients with only subjective symptoms.
†Patients with subjective symptoms plus cervical lesions.
‡Asymptomatic patients.

Tissue culture is considered as the "gold standard" in the diagnosis of chlamydial infections.[1] Since tissue culture techniques are not practical for most clinical laboratories, non-culture antigen detection tests have become available and widely used. Direct fluorescent antibody (DFA) is one of these tests and its advantages over tissue culture are that it does not require a transport system, can detect both dead and live organisms, makes it possible to assess the specimen adequacy, is less expensive, and the results are available days earlier.[1,2] The sensitivity and specificity of the DFA test are in the range of 50–96%, and 94–96% respectively. Therefore, it is recommended as an alternative to the tissue culture in high risk populations.[1,3]

In this study we used the DFA test for screening, since our laboratory facilities were very limited for tissue culture.

The overall infection rate was 34·4% in our study. Similar percentages have been reported in previous studies using similar techniques.[1,4] Our highest positivity rate was found in the 30–40 age group (39·6%). Although chlamydial infections are known as the most prevalent venereal disease in adolescents and young women at child bearing age,[5] this is not true for the Turkish female population, because sexual activity usually begins with marriage and the marriage age has risen (> 25) in the past few years, especially in the cities. Although genital chlamydial infections are reported to be associated with clinical signs and symptoms, they may also show an asymptomatic course. In some studies, the positivity rates in symptomatic women were found to be significantly higher than the control groups.[5] In contrast, there have also been studies in which no significant difference between symptomatic and asymptomatic women has been found.[1,6] In our study, there was no statistically significant difference between the positivity rates of the three patient groups shown in the table. Although the number of patients in the